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	17E242	A. BUILDING _____ B. WING _____	C 08/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL ONAGA LTCU	206 GRAND AVE ST MARYS, KS 66536

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #77210.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility identified a census of 33 residents with 3 residents sampled for accidents. Based on observation, interview, and record review the facility failed to develop a comprehensive individualized plan of care for one (#2) resident of the sample. Findings included: - The clinical record revealed the facility admitted resident #2 on 5/5/14.	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Review of the initial psychiatry evaluation history and physical dated 4/23/14, recorded the resident with recurrent falls.

Review of the Physician's Order Sheet signed 6/2/14 recorded diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Parkinson's (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and total self-care deficit.

Review of the admission Minimum Data Set 3.0 Assessment (MDS) dated 5/14/14 recorded the resident with a BIMS (Brief Interview for Mental Status) score of three, which indicated severe cognitive impairment. The resident displayed inattention and behaviors daily that affected care and the living environment. The resident required supervision for bed mobility, transfers, and walking in the room and corridor, displayed unsteady balance, but was able to stabilize without staff assistance. The resident ambulated independently without any mobility aid and had functional impairment of range of motion to one upper extremity.

Review of the Care Area Assessment summary (CAAs) for falls dated 5/16/14 documented the resident at risk for falls related to his/her Parkinson's, dementia, and poor safety awareness. He/she was not steady with ambulation and transfers from the chair or bed, able to stabilize without staff assistance, no reported falls prior to admission, but had bruises on his/her arms and hands on admission. The resident had a shuffling gait and took small steps

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F 279	Continued From page 2 with ambulation. Review of the plan of care dated 5/16/14, recorded the resident with a self-care deficit due to impaired cognition and poor safety awareness. The resident was able to find his/her room now with a sign with [his/her name] in big letters. The resident's spouse reported the resident would lie down on the floor when his/her shoulder or back hurt. Nursing note dated 5/20/14 at 8:45 A.M. documented a housekeeping staff reported blood on resident's floor and the resident left elbow was bloody. Nursing staff treated the skin tear and placed Steristrips (thin adhesive strips which can be used to close small wounds) on the resident's elbow. Nursing note dated 6/25/14 timed 5:50 P.M., recorded the facility readmitted the resident and documented the resident fell at the acute care hospital, and transferred and ambulated independently bearing full weight on his/her extremities. The admission skin assessment recorded a dark red 1.5 centimeter bruise and stitches to the left eyebrow, multiple healing skin tears, bruising, both legs with two 0.5 centimeter scabbed areas, a 0.25 centimeter scabbed area on the ankle and a yellowish-purple bruise to left hip. Nursing note dated 6/25/14 at 9:50 P.M., documented the resident's spouse was in the room with the resident, went to hold his/her hand while ambulating, when the resident's hand slipped and the resident fell back and hit the occipital area (back of head). Review of the significant change MDS dated	F 279		

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7/7/14 documented the resident with short and long term memory loss, severely impaired decision-making skills, required extensive assistance from staff for transfers, and total assistance from staff for dressing, toileting and personal hygiene. The resident had unsteady balance, was unable to stabilize without staff assistance, had functional limitation of one upper extremity, required a wheelchair for mobility, and experienced one non-injury fall since the prior assessment. This MDS recorded the resident at risk for pressure ulcers and had skin tears.

Review of the plan of care dated 7/11/14 identified the resident with the potential for falls and injury. The plan of care for potential alteration in skin directed:
Reposition every two hours and more often if redness lasted over 30 minutes.
High risk for breakdown due to restlessness and weight loss.
Observe skin during care for redness, pain, change in temperature, or open areas.
Weekly skin assessments by nurse with bath.

The plan of care lacked interventions for skin tears.

Nursing notes dated 7/3/14 (untimed) recorded the resident laid on the floor three times and drugged his/her arm across the floor, the arm started bleeding, and required Steristrips to a 1.8-centimeter skin tear.

Review of the resident's plan of care lacked interventions to protect the resident's skin from repeated skin tears.

Nursing note dated 7/10/14 at 8:15 A.M., recorded staff found the resident lying prone on

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the bathroom floor with a 2.5 centimeter by 2.0-centimeter abrasion to the left lateral forearm, a 3.5-centimeter by 2.0-centimeter skin tear to the right elbow, and a 3.5-centimeter by 3.0-centimeter abrasion to the right shoulder. Staff approximated the skin tear to the elbow with Steristrips.

Observation on 7/30/14 at 9:15 A.M. revealed the resident laid on a pressure reducing winged edge mattress with a cut out center as direct care staff P and Q provided personal care for the resident. Direct care staff Q assisted the resident to a sitting position and then held the resident in the sitting position as direct care staff P replaced the resident's short sleeve shirt with a clean short sleeve t-shirt. Observation revealed the resident without arm protectors, multiple bruises to both arms, and Steristrips to the left wrist.

Observations of the resident on 7/30/14 at 11:00 A.M., 12:15 P.M., 12:36 P.M., 1:00 P.M., 2:40 P.M., 3:50 P.M., and 4:30 P.M., revealed the resident in a short sleeve shirt without arm sleeve protectors to prevent skin tears.

On 7/30/14 at 1:30 P.M. direct care staff P reported the resident experienced a dramatic decline since the return from the geriatric acute hospital. Staff placed alarms on the resident's chair, and a new bed was provided by hospice for fall precautions. Direct care staff P reported the resident took the arm protectors off when staff put them on.

On 7/30/14 at 1:35 P.M. direct care staff O reported the resident use to walk on his/her own and was now a 2-person transfer. The resident took off the arm protectors the staff placed.

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F 279	Continued From page 5 On 7/30/14 at 4:45 P.M. direct care staff S reported the resident had experienced falls and skin tears. The resident was in bed now with staff assisted to change the resident's positions every two hours. The resident should have arm protectors on, he/she did take them off, and then staff would try to put a long-sleeve shirt on him/her. On 7/30/14 at 4:45 P.M. licensed nursing staff J reported the resident wore short sleeve shirts. Licensed nursing staff J stated he/she had seen the resident in arm protectors from day to day. On 7/30/14 at 5:00 P.M. administrative nursing staff D stated staff tried the arm sleeves to protect the resident from skin tears and the resident took them off, however staff should attempt long-sleeve clothing. Administrative nursing staff D reported staff added new care plan interventions along with the date as soon as the interventions were implemented. At this time administrative nursing staff D confirmed the resident's plan of care lacked the intervention for arm sleeve protectors. The facility failed to develop a comprehensive plan of care regarding skin care for this cognitive impaired dependent resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280		

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F 280	Continued From page 6 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 3 residents reviewed for accidents. Based on observation, interview, and record review the facility failed to review and revise the plan of care for 1 resident (#1) related to supervision, assistive devices, and prevention of falls. Findings included: - Review of resident #1's Physician's Order Sheet dated 7/1/14 recorded the diagnosis Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). Review of the Care Area Assessment (CAAs) for falls dated 10/11/13 recorded the resident with Parkinson's disease, a frozen left shoulder (causes pain and stiffness in the shoulder and over time, the shoulder becomes very hard to move), and club foot (a congenital abnormality in which the affected foot appears to have been rotated internally at the ankle). The resident had	F 280		

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balance problems, experienced many falls at home before admission from which he/she received several rib fractures, and required a wheelchair or rolling walker for mobility.

Review of the quarterly Minimum Data Set 3.0 Assessment (MDS) dated 4/2/14 recorded the resident with a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact. This same MDS documented the resident required limited assistance with transfers, dressing, personal hygiene, and toilet use, and supervision with assistance of one staff for walking in his/her room, in the corridor, and on the unit. The resident had limited functional range of motion (ROM) to one side of the body, unsteady balance, and was unable to stabilize without staff assistance.

Review of the resident's comprehensive plan of care for alteration in mobility dated 4/3/14 recorded the resident had the potential for falls and injuries. The resident required an assistive device for ambulation, experienced balance issues, had a left frozen shoulder, and clubfoot, with the interventions:
Staff assistance with all transfers.
Observe for safety when the resident used the wheelchair or 4-wheeled walker.
Physical therapy and Occupational therapy on admission and every 6 months or with any noted decline.
Restorative nursing program after skilled therapy to prevent decline in ROM.
Bed in low position at all times with brake locked except when providing care.
Keep room and hallways clutter free.
Remind the resident to use call light.
Fall risk assessment on admission with MDS

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assessment or change of condition.

Review of the resident's clinical record revealed fall sheets that documented the resident fell on 2/26/14, 3/16/14, 7/7/14, and 7/12/14.

Nursing note dated 7/7/14 at 6:25 P.M. recorded the resident fell on the floor when ambulating to the recliner from the bathroom. Staff failed to use a gait belt, due to resident's request and pain on the left side of his/her body. The resident did not wear shoes and socks due to patient preference. Staff educated the resident about importance of using a gait belt and shoes or socks when ambulating.

The facility investigation documented the new intervention for the resident to wear a gait belt with all transfers and ambulation.

Nursing note dated 7/12/14 timed 6:45 P.M. recorded the resident was ambulating to the toilet at 4:00 P.M., using the walker, gait belt, and one staff assistance, when he/she pivoted to sit on the toilet seat, became dizzy, and bumped his/her left elbow and left chin jawline on the toilet. The resident received a small abrasion on the elbow.

Nursing note dated 7/12/14 timed 7:10 P.M. documented the resident now required two staff assistance with a gait belt for transfers and ambulation.

On 7/30/14 at 7:30 A.M. the resident sat in a high back wheelchair at the dining room table, wore dark shaded sunglasses, special support shoes, and ate breakfast independently.

On 7/30/14 at 8:05 A.M. the resident sat in a high back wheelchair with special support shoes, dark

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sunglasses, and had a yellow-green bruise to the lower left jawline. Direct care staff Q and R placed a gait belt high under the resident's arms and transferred him/her from the high back wheelchair onto the toilet as the resident reached back to hold onto the toilet grab rails.

On 7/30/14 at 11:06 A.M. direct care staff P and licensed nursing staff H placed a gait belt on the resident and assisted the resident with a walker to stand and walk slowly to the bathroom.

On 7/30/14 at 11:15 A.M. direct care staff P reported the resident used his/her call light, did not get up on his/her own, and needed assistance of two staff for transfers.

On 7/30/14 at 1:25 P.M. licensed nursing staff H reported the resident called for staff assistance, wore a special brace shoe for his/her club foot, and was transferred with a gait belt. The resident fell the day he/she returned from the hospital and required assistance of one staff before going to the hospital.

On 7/30/14 at 1:35 P.M. direct care staff O reported the resident required assistance of two staff assistance for transfers from a chair.

On 7/30/14 at 4:45 P.M. direct care staff S reported the resident used the call light and asked for two staff assistance with transfers. Direct care staff S revealed staff used a gait belt and the resident steadied his/her balance with a walker.

On 7/30/14 at 4:50 P.M. licensed nursing staff J reported the resident required staff assistance with balance.

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F 280	Continued From page 10 On 7/30/14 at 4:55 P.M. administrative nursing staff D reported staff added interventions and dated the interventions on the resident's care plan after an incident. On 7/30/14 review of the resident's plan of care lacked evidence regarding the resident's special shoe/brace for the right clubfoot, the intervention to use a gait belt with all transfers, or the intervention for two staff assistance with all transfers and ambulation. The facility failed to revise the care plan for this resident with a history of falls.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 33 residents. The sample included 3 residents reviewed for accidents. Based on observation, interview, and record review the facility failed to provide interventions as planned for the prevention of falls for 2 (#2, #3) residents of the sample. Findings included: - The clinical record revealed the facility admitted resident #2 on 5/5/14. Review of the initial psychiatry evaluation history	F 323		

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and physical dated 4/23/14, recorded the resident with recurrent falls.

Review of the Physician's Order Sheet signed 6/2/14 recorded diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Parkinson's (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and total self-care deficit.

Review of the admission Minimum Data Set 3.0 Assessment (MDS) dated 5/14/14 recorded the resident with a BIMS (Brief Interview for Mental Status) score of three, which indicated severe cognitive impairment. The resident displayed inattention and behaviors daily that affected care and the living environment. The resident required supervision for bed mobility, transfers, and walking in the room and corridor, displayed unsteady balance, but was able to stabilize without staff assistance. The resident ambulated independently without any mobility aid and had functional impairment of range of motion to one upper extremity.

Review of the Care Area Assessment (CAA) for falls dated 5/16/14 documented the resident was at risk for falls related to his/her Parkinson's, dementia, and poor safety awareness. He/she was not steady with ambulation and transfers from the chair or bed, was able to stabilize without staff assistance, had no reported falls prior to admission, but had bruises on his/her arms and hands on admission. The resident had a shuffling gait and took small steps with ambulation.

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Review of the fall risk assessment dated 5/6/14 documented a total score of (13) which indicated a total score of 10 or greater placed the resident at high risk for falls.

Review of the fall care plan dated 5/16/14 listed the interventions:
Wanderguard bracelet at all times, place on ankle and check daily for function. The resident did not tolerate the bracelet on his/her wrist.
Observe for increased problems with gait, shuffling gait was worse on some days related to Parkinson's.
Watch closely on days when there were more people coming in and out the doors.
Make sure resident's shoes were tied.

Review of the fall risk assessment dated 7/1/14 documented a total score of (19) and indicated a total score of 10 or greater placed the resident at high risk for falls.

Review of the significant change MDS dated 7/7/14 documented the resident with short and long term memory loss, severely impaired decision-making skills, required extensive assistance from staff for transfers, and total assistance from staff for dressing, toileting and personal hygiene. The resident had unsteady balance, was unable to stabilize without staff assistance, had functional limitation of one upper extremity, required a wheelchair for mobility, and experienced one non-injury fall since the prior assessment.

Review of the Care Area Assessment (CAAs) for falls dated 7/8/14, documented the facility readmitted the resident on 6/25/14 from a geriatric diagnostic unit. The resident was not steady with ambulation and transferring from

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chair and bed, and not able to stabilize without staff assistance. The resident had a shuffling gait, took small steps when ambulating, and did not use a cane or walker.

The fall care plan dated 7/11/14 listed the interventions:
Chair and bed alarms at all times.
The resident would try to sit down in a chair before he/she got to the chair.
Provided 1 to 1 care when the resident was very restless.
Two staff to walk with the resident due to gait and balance problems and the resident would not tolerate placement of gait belt.
Staff to hold the resident's hands when walking with him/her.
Shuffling gait was worse on some days related to Parkinson's disease.
Make sure the resident's shoes were tied.
The resident began hospice services on 7/14/14 and hospice was providing a hi-low bed with fall mat beside bed.

Nursing note dated 7/10/14 at 8:15 A.M., recorded staff found the resident lying prone on the bathroom floor with a 2.5 centimeter by 2.0 centimeter abrasion to the left lateral forearm, a 3.5 centimeter by 2.0 centimeter skin tear to the right elbow, and a 3.5 centimeter by 3.0 centimeter abrasion to the right shoulder. Staff approximated the skin tear on the elbow with Steristrips. Nursing notes documented the bed alarm did not sound.

The facility provided investigation for the fall on 7/10/14 documented the bed alarm was not connected. The facility action plan documented a fall with non-functioning/not connected pressure alarm and revealed staff was encouraged to

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confirm the resident's bed was in the lowest setting and the alarm on.

Nursing note dated 7/26/14 at 8:00 P.M. documented staff found the resident on the floor with the pressure alarm sounding. The nursing assessment revealed a reddened raised area to the right frontal area of the skull and staff applied a cold compress.

The facility investigation for 7/26/14 documented staff found the resident lying on the floor in his/her room with the recliner (glider) on its side by the resident. The resident's right side of the face was against the wall and staff assessed a 1.0 by 1.0 centimeter area of edema to the left frontal temporal area. The intervention included for the facility staff to speak with the resident's spouse about changing the glider to a recliner.

Observation on 7/30/14 at 9:15 A.M. revealed the resident laid on a pressure reducing winged edge mattress. Observation revealed the resident was unable to maintain an upright position sitting without extensive assistance of staff. Observation revealed multiple bruises to both arms and Steristrips to the left wrist. As direct care staff P repositioned the resident in bed, direct care staff Q reported the connection wire to the alarm box for the sensor pad on the bed, continually fell out of the connection. At this time direct care staff Q reported the tab was broken. Direct care staff P reported, he/she would get a new one and place it on the unit. Observation revealed a glider chair next to the resident's bed.

Observations of the resident on 7/30/14 at 11:00 A.M., 12:15 P.M., 12:36 P.M., 1:00 P.M., 2:40 P.M., 3:50 P.M., and 4:30 P.M., revealed the glider chair in the resident's room next to the bed.

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F 323	Continued From page 15 On 7/30/14 at 1:35 P.M. direct care staff O reported the resident used to walk on his/her own and was now a 2-person transfer. The resident had alarms on the chair/bed for fall precautions. On 7/30/14 at 1:25 P.M. licensed staff H reported the resident tried to get up by him/herself and required one to one assistance from staff when up and moving. The resident had bed and chair alarms for safety. On 7/30/14 at 4:45 P.M. direct care staff S reported the resident had experienced falls and skin tears. The staff assisted to change the resident's positions every two hours and the resident had bed alarms. On 7/30/14 at 5:00 P.M. administrative nursing staff D confirmed the glider chair was in the resident's room and not replaced with a recliner as planned. Administrative nursing staff D reported the facility tried fall mats by the bed but they were a trip hazard and interfered with the resident's ambulation. Administrative nursing staff D reported staff added new care plan interventions along with the date as soon as the interventions were implemented. Review of the fall policy dated 11/2005 documented the purpose, to provide guidelines for the nursing caregiver to follow in order to appropriately assess and provide care for the resident who had fallen as well as to establish protocols for appropriate actions with regard to documentation, and notification of family and physicians. Nursing staff identified, instituted, and followed a specific course of action as soon as possible after the fall occurred.	F 323		

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F 323	Continued From page 16 The facility failed to provide functioning assistive devices and devices as planned for this cognitive impaired dependent resident with a history of falls. - Review of the Physician's Order Sheet for resident #3, dated 7/1/14, recorded the diagnoses: right and left hip arthroplasty (surgical reconstruction process for the hip joints to improve function), dementia (progressive mental disorder characterized by failing memory and confusion), and psychosis (any major mental disorder characterized by a gross impairment in reality testing). Review of the annual Minimum Data Set (MDS) 3.0 Assessment dated 3/5/14 recorded the resident with a BIMS (Brief Interview for Mental Status) score of 99, which indicated the resident was unable to answer the questions. Staff documented the resident with short and long-term memory loss, moderately impaired decision-making skills, required extensive assistance of one staff for transfers, and limited assistance from staff for bed mobility, walking on the unit and in room. This MDS documented the resident with unsteady balance, only able to stabilize with staff, and used a walker for mobility. The resident had functional impairment of range of motion to both lower extremities, was frequently incontinent, and experienced 2 non-injury falls since the previous assessment. Review of the Care Area Assessment (CAA) dated 3/7/14 for cognition recorded the resident was unable to answer the questions for determination of a BIMS score with a diagnosis of dementia. The resident was oriented to	F 323		

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F 323	Continued From page 17 him/herself only and able to follow one-step directions. The CAA for falls dated 3/7/14 recorded the resident experienced two falls in the past before admission and fractured both of his/her hips. The resident experienced a fall at the facility and fractured his/her wrist. This CAA documented the resident was at high risk for falls due to his/her cognition and balance, and was not safe to walk without staff. The resident had bed and chair alarms, a hi-lo bed with a mat on the floor by the bed, and required toileting every 2 hours. The quarterly MDS dated 6/4/14 documented the resident with short and long-term memory loss, moderately impaired decision-making skills, required extensive assistance of one staff for bed mobility and transfers, required limited assistance from staff for walking on the unit and in the room, and total assistance from staff for personal hygiene, dressing, toileting and bathing. The Fall Risk Assessment scores were: 12/9/13 (20); 3/13/14 (22); 6/2/14 (22), a total score above 10 placed the resident at high risk for falls. Review of the plan of care dated 3/4/13 last updated 6/5/14 listed the interventions: Assist with all transfers. Transfer the resident one to one with gait belt. Observe for safety when he/she was in chair or bed. Bed in low position at all times with brakes locked except when doing care. Bed and chair alarms at all times. Keep room and hallways clutter free. Remind to use call light, most likely will not use due to cognition.	F 323		

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Fall risk assessment on admission and with MDS assessments or change of condition.
Nursing restorative program to maintain range of motion after skilled therapy was completed.

Interventions dated 6/5/14 included, when the resident was trying to get up, take him/her to the bathroom, he/she may need to toilet, and offer fluids.

Review of the fall flow sheet dated 2/24/14 timed 9:00 P.M. documented staff found the resident kneeling on the fall mat next to his/her bed.
The facility failed to provide an investigation for this incident.

Review of the fall flow sheet dated 3/7/14 timed 9:45 P.M. revealed staff found the resident kneeling on the fall mat beside the bed, with the bed in the lowest position, and the bed alarm sounded.
The facility failed to provide an investigation for this incident.

Review of the facility provided fall investigation dated 3/16/14 documented the resident with Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The resident was oriented to person, place, and time, used a walker in his/her room, transferred him/herself, and was encouraged to call for staff assistance. The resident had an unsteady gait and generally required assistance of one staff with use of gait belt. Had historically utilized call light appropriately. The investigation revealed the resident did not utilize the call light, although it was within reach. The interventions directed staff to meet the resident's needs in a timely manner

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regardless of how the assistance was required and to encourage the resident to use the call light for assistance.

Review of the fall flow sheet dated 5/7/14 timed 6:00 A.M. documented staff found the resident seated on the floor beside the bed with the mat pushed away from the bedside.
The facility failed to provide a fall investigation for this incident.

Review of the nursing note dated 6/8/14 timed 8:15 P.M., documented staff responded to a chair alarm and found the resident on the floor in the dining room. The fall was not witnessed by staff and the resident had a 2 centimeter hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) bruise on the dorsal (back side) surface of the right hand.

Review of the fall investigation dated 6/8/14 documented the resident with a primary diagnosis of dementia, history of falls, and impulsive with cares and activities. The resident was left in the dining area without close supervision. Review of the facility provided investigation recorded the intervention, staff not to leave the resident unattended in the dining and living room.

Nursing note dated 7/28/14 (untimed) documented staff lowered the resident to the floor. The resident stated, "I let go of my walker and went down."

Observation on 7/30/14 at 12:22 P.M. revealed, staff silenced the chair pressure alarm and assisted the resident to stand with a walker and gait belt, and walked the resident from the living room recliner to the resident's bathroom. The

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resident walked with a shuffling gait and every few steps staff readjusted and straightened the walker direction, while holding onto the walker and gait belt.

On 7/30/14 at 1:25 P.M. licensed nursing staff H reported the resident had dementia, required staff observation when up in a chair, one to one assistance from staff, and a gait belt when he/she walked.

On 7/30/14 at 1:35 P.M. direct care staff O reported the resident had dementia and required one to one assistance to do everything. Staff toileted the resident every 2 hours and before and after meals.

On 7/30/14 at 1:30 P.M. direct care staff P reported the resident was a fall risk, had bed and chair alarms, a Hi-low bed, and a mat on the floor. Staff kept the resident "in line of sight" as he/she would get up and just go and staff toileted the resident every 2 hours.

On 7/30/14 at 4:45 P.M. direct care staff S reported the resident had alarms, did not use the call light, needed staff with him/her when walking, and staff were not to leave him/her alone in their room.

On 7/30/14 at 4:50 P.M. licensed nursing staff J revealed the resident was a fall risk, had alarms, a mat at the bedside, sat in the living room recliner most of the day, and staff kept the resident in view. When the resident tried to get up staff took the resident to the bathroom.

On 7/30/14 at 4:55 P.M., administrative nursing staff D reported staff added interventions and dates to the care plan after an incident.

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F 323	Continued From page 21 Review of the fall policy dated 11/2005, documented the purpose, to provide guidelines for the nursing caregiver to follow in order to appropriately assess and provide care for the resident who had fallen as well as to establish protocols for appropriate actions with regard to documentation, and notification of family and physicians. Nursing staff identified, instituted, and followed a specific course of action as soon as possible after the fall occurred. The facility failed to assess and implement effective interventions, for this cognitively impaired resident with a history of falls.	F 323		